

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4710	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/15/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, KNOXVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 809 EAST EMERALD AVE KNOXVILLE, TN 37917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 001	1200-8-6 Initial Comments  This Rule is not met as evidenced by: During complaint investigation #29060, conducted on March 14, 2012, at NHC Healthcare, Knoxville, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6399

H3T211

If continuation sheet 1 of 1